PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, October 17, 2007

Members & Alternates in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Stanley Block, MD; David Bourassa, MD; Mark Braun, MD; Matthew Burke, MD; Denise Coppa, PhD, RNP; Sarah Fessler, MD; Michael Fine, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; Cynthia Holzer, MD; Christopher Jones, MD; Kohar Jones, MD; Victor Lerish, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD; Andrew Snyder, MD; Richard Wagner, MD. *Associates/Guests*: Fredric Christian, MD; Steven DeToy; Mary Evans; Michael Howe; Elizabeth Lange, MD; Maria Montanaro, MSW; Glen Nelson, MD; Stacy Paterno; Robert Quigley, DC; K. Nicholas Tsiongas, MD, MPH; Bill White, RN, MPH. *HEALTH*: Valentina Adamova; Robert Crausman, MD, MMS; Michael Dexter; Deborah Fuller, DMD, MS; Stephanie Kissam; Patricia Raymond; Peter Simon, MD, MPH; Donald Williams. *PCPAC Staff*: Carla Lundquist; Mary Anne Miller, RN, MPH, CHES; Lisa Raleigh.

Members Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Ellen Gurney, MD; Patrick Sweeney, MD, PhD, MPH.

Dr. Borkan called the meeting to order at 7:33 AM. Minutes of the September 19, 2007 meeting and the advisory letter on EMR usage as a publicly reported performance measure were approved as written (motion by Dr. Wagner, second by Dr. Braun, all in favor). A change of agenda was announced deferring the discussion of Prior Authorization of CTs and MRIs.

Dr. Borkan welcomed guests for the discussion of retail based clinics, and noted that each presenter would be allowed ten minutes, followed by opportunities for rebuttal and discussion. Glen Nelson, MD, Chairman, and Michael Howe, CEO of MinuteClinic, Inc., presented a summary of the principles and features of MinuteClinic (MC). Key points:

- MC is designed to improve access to care as an adjunct to the medical system and is not a medical home. The MC scope of services is narrow to focus on the things the company feels it can do in a superior fashion.
- Access to Care: MC provides extended evening and weekend hours, walk-in access at convenient locations, and accepts most commercial insurances.
- Continuity of Care: MC uses a centralized EMR accessible by any MC location, shares records with primary providers (electronically, fax, or mail), supports and facilitates medical homes via triage and referrals, and collaborates with local physicians.
- Quality of Care: MC adheres to national standards of practice (ICS, AAP, AAFP), Desired Attributes of Retail Health Clinics (AAFP, AMA), and is Joint Commission accredited. Their proprietary EMR includes embedded clinical guidelines and best practices for decision support. The EMR indicates triage/referral need as appropriate per inputs.
- MC studies indicate high guideline compliance, outcome quality, and patient satisfaction.

Elizabeth Lange, MD, Vice President, AAP RI Chapter, provided a counterpoint presentation on primary care concerns about retail-based clinics (RBCs). Key points from Dr. Lange:

- The scope of care provided by RBCs is insufficient; the narrow focus requires patients to self-diagnose before going to the RBC, and the "simple visit" concept is fallacious and can lead to missed or ignored conditions. The RBC visit cannot be used as an opportunity for a wider review of the patient's chart, medications, and tests, as is done in the medical home. Follow-up care is not available from the RBC, which will not have medical records, lab results, etc.
- There is an inherent conflict of interest having RBCs in pharmacies, which may result in higher prescription rates, over utilization of OTCs, and pharmacy-only solutions.
- Quality Oversight - There is no method to monitor patient safety, recurrences, and medication reconciliation across RBCs. Multiple RBC sites may send reports for the PCP to assimilate without being involved in the care.
- RBC facilities are not held to same standards as physician offices. Waivers of basic public health regulations and standards (e.g. waiting rooms, sinks in all exam areas, exam tables, dedicated restrooms, infection control measures) for a for-profit company in order to compete with other health care providers, allowing for the lower cost of services, is unfair to providers who are struggling to meet a greater set of regulatory and licensure requirements
- The state of primary care in RI is precarious, with the lowest reimbursements in US and thinnest margins, and RBCs will worsen the fragmented and inappropriate utilization patterns while skimming off profitable patient visits. RBCs do NOT support the medical home, and will be part of the problem for our health care system, not part of the solution

In his rebuttal, Dr. Nelson noted that much of Dr. Lange's presentation was hearsay, not hard data as MC presented, and doubted that many patients contact their PCP following a MC visit. He argued that physicians are more likely to over-prescribe antibiotics than MC nurse practitioners. Dr. Lange countered that she could document and attest that many patients contact their pediatrician about after-hours care received at walk-in centers.

Dr. Block asked about provision of care to patients uninsured/unable to pay. Mr. Howe stated that the MC model is designed to provide care at lower cost, and payment for services is not adjudicated until the end of the visit. Dr. Gifford commented that hospitals and home health care organizations must meet charity care requirements, as do other entities

(such as surgery centers) which have requirements levied on them under CON approval. PCPs seem to be concerned about an un-level "playing field" in terms of the business environment for primary care practices and RBCs. Should that mean licensing all physician offices as well? Dr. Block replied that MC is more than a medical office; it is a national for-profit retail organization. Health centers operate under regulations that are extensive and expensive, and they are concerned about competing against a national for-profit business not subject to the same requirements.

Dr. Coppa remarked out that the RBC model is in direct competition with the urgent care model, not primary care practices. This is adjunctive care, and RBCs do not claim to be maintaining primary care practices. RBCs would not be challenging PCPs in RI, and the dialog should back up and compare them with urgent care centers and ERs.

Dr. Snyder and Dr. Braun both commented that RBC communications are outbound only; seeing a patient with a potentially serious condition, without access to a medical history or other diagnostic services, is not going to lead to high-quality care. Sharing of information via a centralized patient record might work across MCs, but not all RBCs, which just fax information to the PCP. Getting a fax does not help PCPs when they get a day after call from a patient seen at an RBC and still having a health issue. The PCP cannot rely on the reports alone and needs to see the patient, which will raise costs. Insurers will complain to PCPs about over-consumption of resources whether or not the PCP sent the patient to the RBC. How can PCPs put an EMR in place to share data if they cannot get reimbursed for the services they provide now?

Mr. Howe noted that in the interest of time he did not cover all the slides in his presentation, and the last page in the handout shows MC as one of many entities adjunct to the medical home. MC is not meant to be a medical home, and educates patients on the importance of having a primary care provider. 30% of MC patients report they do not have a PCP, which is why the company sees a role for RBCs in health care. MC would like to share data/medical history with all health care access points, but only 15% of PCPs nationally have EMR. Regarding financial concerns, MC has 321 sites in 25 states and has found little financial impact to PCPs. Physicians in MN have seen MC help facilitate medical homes.

Dr. Gurney stated that pediatrics is a very different specialty from adult medicine; children are not miniature adults, and they are dynamic and complex. There are brief windows of opportunity to make certain diagnoses; if the child goes outside the medical home for care (excepting conditions requiring the ER), an opportunity to evaluate the child as a whole is lost. Dr. Gurney does not see a role for RBCs in the treatment of young children; children need to see their PCP when they are sick. In RI there is no excuse for any child not to have a medical home; it is a small state, and distances to health care are not impossible. RI needs to strengthen access to PCPs and medical homes, especially for non-English-proficient populations. There is a real danger that accessing medical care at an RBC may cause a serious problem to go unnoticed.

Dr. Goldberg remarked that RBCs do not address some of the most common patient complaints, including orthopedic issues, muscle spasms, back pain, and particularly mental health. PCPs cannot "pre-screen" the patients they want to see to avoid complex, time-consuming visits. He expressed concern that care at RBCs will be strictly protocol-driven, with blithe referral of patients with larger issues to PCPs and no accountability for the RBC to address those patients' needs.

Dr. Fine, speaking as a former Chair of PCPAC and as the facilitator of the Primary Care Leadership Council, noted that licensing of Organized Ambulatory Care Facilities (OACF) exists to protect the public when no individual physician is responsible for care at a practice site. The bulk of primary care practices in RI operate under the licenses of the physicians who are responsible for patient care. Dr. Fine expressed concern that the primary care community is continually beset by responsibilities and requests from all quarters, all of which are "adjunct" to primary care, but produce extra work for PCPs with no additional business value. This includes radiology pre-authorizations, vaccine administration regulations, and insurer prescription limits, a constellation of challenges. The health of primary care practices is being pulled apart, and RBCs will not improve the already difficult primary care environment.

Dr. Basile pointed out that people are talking about the "medical home" as though it actually exists now. Many people are working hard to create the patient-centered primary care medical home in RI, but it has not yet been achieved. The medical home concept seeks to have NPs work with physicians in a primary care team, but RBCs would redeploy NPs elsewhere. RBCs would be a low-value drain on a fixed pie of resources, making it harder to create the medical home.

Dr. Nelson commented that he agrees with much that has been said about the basic medical tenets of caring for children and adults, but there are circumstances where the system is failing. Patients will go to their medical home if they have access to evening/weekend care, but PCPs are not meeting this need, which MC seeks to fill. In Dr. Nelson's opinion, the best thing that could happen is that PCPs could adopt things MC is doing, and MC would become unnecessary. But PCPs need to ask themselves if they are providing what their patients need. Fast access and early intervention can make a big difference, and does not impact patients seeing their PCP for the myriad services of longitudinal care.

Dr. Puerini spoke about the huge movement in RI and across the county to put more emphasis on primary care and prevention, in contrast to the current over-emphasis on procedurals and reimbursement. People will visit RBCs with minor problems for a quick fix; but this is diametrically opposed to primary care and prevention, and patients do not understand that is not the way to receive medical care. The RI Primary Care Physicians Corporation has worked with the

quality walk-in centers in RI to coordinate care and provide access to care. If a patient's PCP is not available, they can be referred to a facility staffed by physicians and dedicated to health care in a hygienic, properly equipped setting.

Dr. Lerish said that if one of the purposes of MC is to meet unmet needs, then judging by the application submitted and withdrawn last year, they are focusing on the wrong communities. In the affluent communities targeted in the application, the large primary care practices provide evening and weekend services, and they do not make sense for RBC locations.

Ms. Miller asked if MC has compared their patients with ER and walk-in center utilization. Mr. Howe replied that tracking has been done for some MC sites; and they have seen an initial reduction in ER utilization for the conditions MC sees. They have not yet compared with urgent care facilities. Ms. Miller asked if MC ever turns away uninsured patients, or those unable to pay. Mr. Howe explained that MC adjudicates the financial piece at the end of the visit.

Don Williams, Associate Director for Health Services Regulation, noted that if MC were to be licensed in RI, it would be as an OACF. He pointed out that although there are issues to be addressed regarding variance requests, there is no legal impediment to licensure of RBCs in the state. There is tremendous demand among consumers for the services RBCs provide, and the arguments of the primary care community, saying that consumers do not know what is best for them, are very paternalistic. Dr. Snyder replied that physician offices are subject to regulations and other constraints that remove them from typical market competition. PCPs cannot adjust prices to compensate for increased overhead costs. RBCs are not a true fix for the access issue; they will make it harder to achieve the ultimate goal of patient-centered medical homes.

Dr. Borkan voiced his appreciation for the comments of all participants, and polled the PCPAC voting members present (n=16) on ten questions regarding Retail-Based Clinics:

1. **Will the introduction of Retail-Based Clinics (RBCs) improve the overall health and health care of the people of RI?** Yes=0; **No=15** [Borkan, Basile, Block, Braun, Burke, Coppa, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]; Unsure=1 [Bledsoe]
2. **Is there an issue of access to health care for the people of RI? Yes=16** [Borkan, Basile, Bledsoe, Block, Braun, Burke, Coppa, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]; No=0; Unsure=0
3. **Will the introduction of RBCs help with access to care?** Yes=2 [Burke, Coppa]; No=0; **Unsure=14** [Borkan, Basile, Bledsoe, Block, Braun, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]
4. **Will the introduction of RBCs improve the environment for primary care practices in the state?** Yes=0; **No=16** [Borkan, Basile, Bledsoe, Block, Braun, Burke, Coppa, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]; Unsure=0
5. **Will the introduction of RBCs facilitate movement toward the patient-centered medical home for the people of RI?** Yes=1 [Coppa]; **No=13** [Borkan, Basile, Block, Burke, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]; Unsure=3 [Bledsoe, Braun]
6. **Will the introduction of RBCs improve (decrease) fragmentation of care?** Yes=0; **No=13** [Borkan, Basile, Braun, Burke, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Puerini, Wagner]; Unsure=3 [Bledsoe, Block, Coppa]
7. **Do some of the elements of RBCs need to be incorporated into the primary care system in our state?** Yes=0; **No=12** [Borkan, Bledsoe, Burke, Coppa, Fessler, Fine, Goldberg, Holzer, C. Jones, Lerish, Maxim, Wagner]; Unsure=4 [Basile, Block, Braun, Puerini]
8. **Conflict of Interest – Are pharmacies an acceptable venue for the provision of care?** Yes=0; **No=12** [Borkan, Basile, Bledsoe, Block, Braun, Burke, Coppa, Fine, Holzer, C. Jones, Maxim, Puerini]; Unsure=4 [Fessler, Goldberg, Lerish, Wagner]
9. **Should there be any waiving of regulations (facility or provider) to allow for the introduction of RBCs in RI?** Yes=0; **No=13** [Borkan, Bledsoe, Block, Burke, Coppa, Fessler, Fine, Goldberg, Holzer, C. Jones, Maxim, Puerini, Wagner]; Unsure=3 [Basile, Braun, Lerish]
10. **Should RBCs be responsible for the same language/interpretation requirements as other facilities? Yes=11** [Borkan, Basile, Bledsoe, Block, Burke, Fessler, Fine, Goldberg, Holzer, C. Jones, Puerini]; No=1 [Coppa]; Unsure=4 [Braun, Lerish, Maxim, Wagner]

Dr. Borkan thanked everyone who came to talk and hear about this high-interest issue for the primary care community. There is a need to be met in access to care, and whether RBCs are part of that solution in RI remains to be seen. Ms. Miller announced that in observation of National Primary Care Week, members would be presented with National Health Service Corps books and tote bags, to affirm the contributions of all providers to the Committee.

NEXT PCPAC MEETING: WEDNESDAY, NOVEMBER 28, 2007

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